1988

David F. Tibbetts v. Suzanne Dandoy : Brief of Petitioner

Utah Court of Appeals

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IN THE COURT OF APPEALS OF

THE STATE OF UTAH

DAVID F. TIBBETTS, Petitioner,	)	
v.	)	Case No. 880063-CA
SUZANNE DANDOY, In Her Capacity as Executive Director of the Utah Department of Health, Respondent.	)	Category No. 14 a

BRIEF OF PETITIONER

Appeal from a decision of the Fourth District Court, dated November 25, 1987 (Civil No. CV86-2279), granting Respondent's motion for summary judgment and denying Petitioner's motion for summary judgment.

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IN THE COURT OF APPEALS OF

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Petitioner,	)	
v.	)	Case No. 880063-CA
SUZANNE DANDOY, In Her Capacity as Executive Director of the Utah Department of Health,	)	Category No. 14 a
Respondent.	)	

BRIEF OF PETITIONER

STATEMENT OF JURISDICTION

Jurisdiction is conferred upon this court pursuant to Utah Code Ann. § 78-2a-3(2)(a).

NATURE OF THE PROCEEDINGS

This is an appeal from a final order of the Fourth District Court granting summary judgment to the respondent and denying summary judgment to petitioner. (Record, at 93) (hereinafter referred to as "R") The action in the district court was commenced pursuant to Utah Code Ann. § 26-23-2 (1953) and sought review of a final determination by the Executive Director of the Department of Health denying petitioner Medicaid assistance. (R-1)

STATEMENT OF THE ISSUES

1. Whether respondent erred as a matter of law in finding that petitioner's home was not exempt as an asset under the Medicaid statute?

2. Whether respondent should be equitably estopped from denying petitioner Medicaid?

DETERMINATIVE CONSTITUTIONAL PROVISIONS, STATUTES, ORDINANCES AND RULES

The following relevant sources are reproduced in the addendum section:

Utah Code Ann. § 26-23-2(3)

APA Vol. III § 411.1

45 C.F.R. § 233.20(a)(3)(B)

42 C.F.R. §§ 435.812-.814

42 C.F.R. §§ 435.840-.843

STATEMENT OF THE CASE

This is a review of final agency action by the Department of Health upholding a denial of Medicaid benefits to petitioner. (R-18) Petitioner originally sought review in the district court which issued an order on November 25, 1987, upholding respondent's action. (R-93) Petitioner seeks review of that order in the Court of Appeals. (R-106)

During December, 1985, petitioner applied for retroactive Medicaid benefits to cover the cost of dental care needed by his four children. (R-34) Petitioner was

advised by caseworkers in respondent's Provo office that his children were eligible for Medicaid for the month of December and that he should go ahead and obtain the necessary treatment. (R-20, 31, 33, 34, 38, 39) Although petitioner requested Medicaid coverage, his application was not filed until January 3, 1986. (R-33-34) Petitioner paid $87.35 as a medical excess for the month of December, since his countable income exceeded the basic maintenance standard for a family of his size.[1] After the dental treatment had been provided, a second caseworker reviewed petitioner's Medicaid file on or about March 26, 1986, and concluded that he was not eligible because of excess assets. (R-32) The asset which allegedly rendered petitioner ineligible for Medicaid was a six and one-half acre portion of a lot owned by him in Genola, Utah. (R-36-38) At the time of his application, petitioner owned an eight acre lot in Genola over which a dirt path existed. (R-4-5) The path was used by the city of Genola to reach a water tower located to the rear of petitioner's property. (R-5) The path divided the eight acre plot into six and one-half acres on one side and one and one-half acres on the other. (R-4-5)

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[1] A medical excess payment must be paid under Utah's medically needy program whenever an applicant's household income exceeds the standard set by the state. See discussion, infra, at 5.

The second caseworker determined that because of the excess assets, petitioner was not eligible for Medicaid in December, 1985, and returned the spenddown to him. (R-34) Respondent refused Medicaid coverage of the December dental treatment. Petitioner then requested a hearing which was held on April 9, 1986, before Fair Hearing Officer Neal Bernson. (R-31) Petitioner was unrepresented by legal counsel at the hearing. (R-31) Officer Bernson issued a recommended decision on July 31, 1986, finding that petitioner's Medicaid application for December, 1985, had been properly denied. (R-19) On or about August 7, 1986, the respondent, Executive Director Suzanne Dandoy, adopted the hearing officer's recommendation. (R-18) The review in the district court followed that decision.

STANDARD OF REVIEW

Pursuant to Utah Code Ann. § 26-23-2(3), the district court reviewed the final agency action under the following standard:

> "If the final determination of the executive director is consistent with the findings of fact and conclusions of law recommended by the hearing officer, the court shall review the record and may alter the final determination only upon a finding that the final determination is capricious, or not supported by the evidence."

This court has held that an appeal from a district court which has reviewed an administrative decision is reviewed just as if the appeal had come directly from the agency.

TechnoMedical Labs v. Securities Division, 744 P.2d 320, 321 n.1 (Ut. App. 1987) The court further noted that the standard of review applicable to such reviews is that of "reasonableness or rationality." Id., at 323. The court noted:

> Under this standard, the agency's decision will be set aside 'only if it is outside the tolerable limits of reason' or 'so unreasonable that it must be deemed capricious and arbitrary.' Id., at 323.

The Utah Supreme Court has further held that when an appellate court reviews an agency decision, an intervening court decision is entitled to no presumption of correctness, since the lower court did not have a more advantaged position for reviewing the administrative record. Bennion v. Utah State Board of Oil, Gas and Minerals, 675 P.2d 1135, 1139 (Ut. 1983)

SUMMARY OF THE ARGUMENT

Under the federal Medicaid program, an applicant's home is excluded as an exempt resource. Respondent is bound by the federal regulations and must make a reasonable application to individual cases. Respondent interprets the federal regulation as exempting a home and an average size lot in the community where it is located. Respondent has erred in petitioner's case by finding that a path or trail across petitioner's property legally divided his property, leaving a parcel of land that must be sold. Substantial evidence is lacking for the finding that petitioner owned

two parcels of land, one of which is subject to sale. Respondent's application of the regulation and her own policies and procedures is unreasonable in petitioner's case.

Respondent, through her representative caseworkers in the Provo OCO office, represented to petitioner that his children were eligible for Medicaid during December, 1985. Petitioner relied on those representations and had certain dental work performed. Subsequently, respondent's representatives disavowed their earlier statements and declared petitioner ineligible because of excess assets. Petitioner has relied to his detriment and respondent should be equitably estopped from denying him Medicaid benefits.

ARGUMENT

POINT I

The District Court Erred As a Matter of Law In Finding That Petitioner's Home Was Not An Exempt Asset Under The Medicaid Statute.

The Medicaid program was established by Congress in 1965 as Title XIX of the Social Security Act. The program, which is designed to provide federal financial assistance to those states choosing to reimburse needy persons for certain medical treatment costs, is codified at 42 U.S.C. § 1396 et seq. Individual states are not required to participate in Medicaid, but once they decide to do so, they must comply with federal law. Townsend v. Swank, 404

U.S. 282, 286, 92 S.Ct. 502 (1971) If a state chooses to participate in the Medicaid program, the federal government will reimburse the state for a portion of the cost. 42 U.S.C. § 1396b In Utah, approximately seventy percent of the Medicaid budget is supplied by the federal participant.

Medicaid does not provide assistance to every poor person in need. The program is intentionally designed to provide a health benefit component linked to other financial assistance programs. For example, persons qualifying for Aid to Families with Dependent Children (AFDC) are considered "categorically needy" and are thereby mandatorally eligible for Medicaid. 42 U.S.C. § 1396a(a)(10)(A)(i); 42 C.F.R. § 435.100 et seq. An optional category of eligibility, which is the category at issue in this case, is "medically needy". This classification includes those who have income or resources above the limits for AFDC but below the state-established "medically needy" limit and who meet all other non-eligibility criteria for AFDC. Thus, medically needy recipients include persons who are AFDC-like (needy children and their parents) and who have income and resources within the applicable limits. 42 U.S.C. § 1396a(a)(10)(C) Utah has opted to cover this group of individuals and frequently requires payment of a spenddown or, the amount by which income exceeds the basic maintenance standard, if the applicant's household income exceeds the established standard of need for a household of that size.

In this case, petitioner's children qualified as medically needy children and petitioner was required to pay a spenddown in order to receive Medicaid coverage for December, 1985.

The federal regulations implement the statutory authority for extending Medicaid to medically needy individuals. 42 C.F.R. § 435.300 et seq. The regulations provide that a state Medicaid agency may provide Medicaid to individuals who have income that meets the standards set forth in 42 C.F.R. §§ 435.812-.814 or, if their income exceeds these standards, allow eligibility if the incurred medical expenses equal the difference between countable income and the applicable income standard. Persons qualifying for medically needy coverage must also meet the applicable resource standards in 42 C.F.R. §§ 435.840-.843.

The applicable medically needy resource standards require that eligibility be determined using a resource standard that is based on family size, is uniform for all individuals and is reasonable. 42 C.F.R. § 435.840. A medically needy resource standard is presumed to be reasonable if it equals the highest resource standard for the cash assistance group or program related to the covered medically needy group. In this case, petitioner's family is properly classifiable as related to the AFDC cash assistance group. Therefore, the AFDC resource standards are applicable to petitioner's case.

The applicable AFDC resource standards are found at 45 C.F.R. § 233.20 (a)(3)(B) and provide in relevant part:

> A State Plan ... must ... [s]pecify ... in AFDC--The amount of real and personal property that can be reserved for each assistance unit shall not be in excess of one thousand dollars equity value (or such lesser amount as the State specifies in its State plan) excluding only:
> (1) The home which is the usual residence of the assistance unit;
> ....

The state of Utah implements the federal regulations through its local Office of Community Operations (OCO) offices. To aid the local offices, state authorities publish volumes of policies and procedures which are to guide caseworkers in applying the federal statute and regulations. In this case, respondents promulgated APA Vol. III § 411.1, which provides in relevant part:

> 1. <u>One Home and Lot - All Cases</u>
>
> Exclude one home...and lot owned or being purchased and occupied by the client.
>
> a. The lot on which the home stands shall not exceed the average size of residential lots in the community where it is. Count the equity value of property exceeding the average size lot.

It was this section of respondent's rules that the caseworker applied in March, 1986, in finding that petitioner had excess resources for the medically needy program.

Although a state participating in the Medicaid program is permitted to make eligibility determinations, the

issue of AFDC eligibility, and in this case Medicaid eligibility, is ultimately a question of federal law. Herndon v. Colorado, 528 P.2d 395 (Colo. App. 1974) The state of Utah is permitted to adopt policies and procedures such as APA Vol. III § 411.1, but the rules adopted must be reasonable and not in derogation of the federal statute. Rosen v. Hursh, 329 F.Supp. 322, 324 (D. Minn. 1971) rev'd on other grounds, 464 F.2d 731. Moreover, the state Medicaid participant has an affirmative duty to show the reasonableness of its policies. Amos v. Dept. of Health and Resources, 444 S.2d 43 (Fla. App. 1983)

It should first be noted that the applicable federal regulation says nothing about the size of the lot on which a home may be situated. The term "lot" and "average size" are not defined in the federal regulations. The exclusion of an average size lot is a state gloss upon the federal regulations which must be reasonable if it is to survive judicial scrutiny. Moreover, the state's policies and procedures derived from the regulation must be reasonable in their application. In this case, the state of Utah failed in its responsibility to reasonably apply the federal Medicaid statute and regulations.

It is apparent from reviewing the transcript of petitioner's case, that the caseworker involved had determined in her mind that the "road" bisected petitioner's lot, thereby effecting a legal division of his property into

separate parcels, one of which qualified as a lot connected with his home and the other a parcel subject to sale. At one point the caseworker even referred to the one parcel as being "across the street." (R-35) Absent from the record, however, is any evidence of a route established across petitioner's property which could be classified as a legal road or some other dividing line having legal status. Petitioner testified that the route was more on the order of a path or trail, was not blacktopped or maintained by the city of Genola and did not appear on an official plat of the city. (R-4-5, 46) It appears that the road is no more than a vestige of the city's infrequent passage over petitioner's property which mushroomed in the caseworker's mind until it attained legal status, despite the lack of any reference to an easement or right-of-way on the city plat. (R-46) Were the caseworker's concept of property division to apply in all cases, a footpath developed by school children across a Medicaid recipient's property could in time result in Medicaid disqualification, since the passage of little feet could establish a "road" just as surely as the infrequent crossing of city vehicles operated by the City of Genola. If the respondent is correct, a farmer's property divided by a cowpath could disqualify him from Medicaid. Such results would hardly be considered reasonable.

In addressing the issue of home exemption, respondent ignored her own policies which provide that a lot is

excluded if it does not "exceed the average size of residential lots in the community..." Petitioner established through introduction of the plat that his lot is indeed an average size lot for the community of Genola, Utah. (R-46) A visual comparison of petitioner's lot with those of others in the plat shows that it is smaller than the majority of the properties contained therein.

Perhaps the best indication that the lot owned by petitioner is not subdivided is the city plat introduced at the hearing. (R-46) The plat shows petitioner having legal ownership of the entire eight acre plot. The troublesome path or "road" is not even entered on the plat map. Petitioner's legal description, as stated in a recent tax notice, contains no reference to an easement or right-of-way over his lot and shows him as owning an undivided interest in 8.14 acres. (R-70) Thus, petitioner owns all of the land over which the path crosses and his evidence of ownership outweighs any supposed division created by the caseworker.

Even assuming that five acres is the average size lot for Genola (which the plat shows is not the case), petitioner's ownership of an eight acre lot does not automatically render him ineligible for Medicaid. Instead, respondent's regulations provide that only the equity of the excess property exceeding the average size is counted. In this case, the parcel exceeding the average size lot for the

City of Genola would have questionable equity value, since it would be less than the minimum size lot required by the city. Moreover, such excess would be restricted in access to irrigation water and would have limited agricultural value. Clearly, the record does not contain substantial evidence of the equity value of property belonging to petitioner, regardless of how it is divided.

POINT II

Respondents Should Be Equitably Estopped From Denying Petitioner Medicaid Benefits.

A further issue which arises in petitioner's case is whether the doctrine of equitable estoppel should apply so as to estop respondent from denying petitioner Medicaid benefits. It is evident from a review of petitioner's hearing transcript that he considered himself misled by caseworkers in the Provo OCO office concerning his Medicaid eligibility. He testified without contradiction that he was told by caseworkers that his children would be eligible for Medicaid benefits during the month of December and he should go ahead and have the necessary dental work performed. (R-31, 33, 34, 38, 39,) Based on the representations by respondent's representatives in the Provo OCO office, petitioner proceeded to have the dental care performed for his children. He testified that he even received a letter stating that he had been approved for Medicaid during the month of December. (R-33) Petitioner testified that he did

not fail to disclose the property which is the subject of this appeal and, in fact, "told everybody about that property." (R-36) Petitioner testified that he relied on the representation that he had been approved for Medicaid assistance and, had the representations not been made, he would not have had the dental work performed. (R-40) The hearing examiner in his findings of fact concluded:

> He called the district office, explained his circumstances and was informed that his children would qualify for dental work that needed to be done. Therefore, he had the dental work done and applied for Medical Assistance in January, 1986 as he was advised to. He was even told how much excess income to pay which he did on January 10, 1986. If he is not eligible now based upon excess assets, then he can understand why he would be ineligible for ongoing assistance. He, however, feels that because of the mistake of the district office in approving him in error, that the payment to the dentist should be made in behalf of his children.

(R-43)

The doctrine of equitable estoppel is well established in Utah jurisprudence. In Celebrity Club, Inc. v. Utah Liquor Control Commission, 602 P.2d 689, 694 (Ut. 1979) the court observed that equitable estoppel may be applied against the state even when it is acting in its governmental capacity, if it is necessary to prevent manifest injustice and the exercise of governmental powers will not be impaired thereby. See West v. Department of Social and Health Services, 586 P.2d 516, 518 (Wash. 1978) The Utah court set out the essential elements of equitable estoppel as follows:

(1) an admission, statement, or act inconsistent with the claim afterwards asserted,
(2) action by the other party on the faith of such admission, statement, or act, and
(3) injury to such other party resulting from allowing the first party to contradict or repudiate such admission, statement, or act.

Id., at 694.

In Utah State University v. Sutro & Company, 646 P.2d 715 (Ut. 1982) the Utah Supreme Court reviewed the long history of the doctrine of equitable estoppel and reiterated its holding that "estoppel should be allowed as a defense against the government where to do otherwise would work a serious injustice, and the public interest would not be unduly damaged by the interposition of that defense." Id., at 719. The court cited with approval the decision in United States v. Wharton, 514 F.2d 406 (1975) wherein:

> The court noted the precaution that not every form of official misinformation would be sufficient to estop the government, but where advice given was so closely related to basic fairness and the decision-making process, the government should be estopped from disavowing the representation made because to do so would work a serious injustice on the defendant and the interest of the public would not be unduly threatened or damaged.

Utah State University v. Sutro & Company, supra, at 720.

The court concluded:

> We regard the authorities referred to above as well reasoned, with which our sense of justice is in harmony, and supportive of the well-recognized policy of the law as earlier set forth herein, to the effect that the rule which precludes the assertion of estoppel against the government is sound and generally should be applied, except only in appropriate circumstances as hereinabove stated, where the interests of justice mandate an exception to that general rule. In cases where

> such an issue arises, the critical inquiry is whether it appears that the facts may be found with such certainty, and the injustice to be suffered is of sufficient gravity, to invoke the exception. And in case there is doubt on such matters, it should be resolved in favor of permitting the party to have a trial of the issue, as opposed to summary rejection thereof.

Utah State University v. Sutro & Company, supra, at 720.

Several courts in other jurisdictions within this region have applied the doctrine of equitable estoppel in the context of public entitlements. In Glover v. Adult and Family Services Division, 613 P.2d 495 (Or. App. 1980) the court held that equitable estoppel could apply to the case of a Medicaid recipient who had been advised that her children were eligible for dental coverage and who had not been informed of the need for prior authorization. The court held that if petitioner's version of the facts were believed, a case for estopping the agency from applying its rules had been presented. Id,. at 499. Similarly, in Filipo v. Chang, 618 P.2d 295 (Haw. 1980) the court estopped the Hawaii Social Services agency from asserting the invalidity of certain welfare regulations when the agency's own misfeasance and nonfeasance had been responsible for the noncompliance. Id., at 300. The court observed:

> Government, above all, must be above reproach. Equity and fairness dictate that it should not be permitted to take advantage of its own wrong or mistake. R. H. Stearns Co. v. United States, 291 U.S. 54, 54 S.Ct. 325, 78 L.Ed. 647 (1934). A citizen has a right to expect the same standard of honesty, justice and fair dealing in his contact with the State or other political entity, which he is legally accorded in his dealings with other

> individuals. Finch v. Matthews, 74 Wash.2d 161, 433 P.2d 833 (1968).

Id., at 300.

For the same reasons set forth in the above-cited case law, the doctrine of equitable estoppel should be applied in this case. Petitioner dealt honestly with respondent in attempting to obtain Medicaid coverage for his children's dental needs. He testified repeatedly and without contradiction that he had been told by Medicaid caseworkers in the Provo office that his children were eligible for Medicaid and he should go ahead with the dental work. It is clear that he relied to his detriment on a representation by respondent that the service would be covered. It was not until three months after the representation that respondent disavowed her earlier statement. A manifest injustice would result unless respondent is estopped from denying eligibility. The public interest would be well served by such a holding, since it would promote confidence in the social service system operated by the state of Utah. In comparison with the state's overall budget, the amount in question is likely small. The sense of fairness and prevention of injustice to a vulnerable individual would accrue to the state and the public as a lasting value.

CONCLUSION

Petitioner has established that he was eligible for Medicaid during December, 1985, because the home he was living in was exempt. The lot on which the home was situated was also exempt, since it did not exceed an average size lot for the community where he lived. Respondent has failed to establish that petitioner owned a separate parcel of land subject to sale. Therefore, respondent's disqualification of petitioner was an unreasonable application of the federal statute and regulations. Moreover, respondent should be equitably estopped from denying petitioner Medicaid, since her own representations caused him to act to his detriment. For these reasons, petitioner requests that the court reverse the decision of the district court and enter its order requiring respondent to award him Medicaid benefits for the month of December, 1985.

DATED this 9 day of June, 1988.

Michael E. Bulson

MICHAEL E. BULSON
Attorney for Petitioner

A D D E N D E M

name of the department at any time and place, in accordance with rules and procedures for administrative hearings adopted by the department. Minutes or a summary of the proceeding of such hearing shall be taken and filed with the department records, together with recommended findings of fact and conclusions of law made by the hearing officer, from which the executive director shall make a final determination. In any such hearing, the hearing officer shall have authority to administer oaths, examine witnesses, and issue in the name of the department notice of the hearings or subpoenas requiring the testimony of witnesses and the production of evidence relevant to any matter in the hearing. Hearings shall be conducted in a manner which guarantees the parties' due process rights. This includes, but is not limited to, the right to examine any evidence presented to the department or hearing officer, the right to cross-examine any witness, and a prohibition of ex parte communication between any party and a member of the committee or the hearing officer. Final rules incorporating these procedures shall be adopted by the committee on or before October 1, 1988.

(2) Judicial review of a final determination of the executive director may be secured by the aggrieved party by filing a petition in the district court within 30 days after receipt of notice of the executive director's final determination. The petition, which shall be served upon the executive director, shall state the grounds upon which review is sought. With his answer, the executive director shall certify and file with the court all documents and papers and a transcript of all testimony taken in the matter, together with the recommended findings of fact and conclusions of law of the hearing officer, and the final determination of the executive director.

(3) If the final determination of the executive director is consistent with the findings of fact and conclusions of law recommended by the hearing officer, the court shall review the record and may alter the final determination only upon a finding that the final determination is capricious, or not supported by the evidence.

(4) If the final determination of the executive director is not consistent with the findings of fact and conclusions of law recommended by the hearing officer, the executive director shall prepare and file with the court at the time of filing the answer to the petition, findings of fact and conclusions of law to support the final determination of the executive director. The petitioner shall have 15 days after receipt of the executive director's findings of fact and conclusions of law to amend the petition for review. The court may affirm or amend the final determination of the executive director, or require further or additional testimony necessary to be taken, and issue an order based on its own findings of fact and conclusions of law. 1987

26-23-2. (Effective January 1, 1988). Administrative review of actions of department or director.

Any person aggrieved by any action or inaction of the department or its executive director may request agency action and appropriate adjudicative proceedings. Hearings shall be conducted in a manner which guarantees the parties' due process rights. This includes, but is not limited to, the right to examine any evidence presented to the department or hearing officer, the right to cross-examine any witness, and a prohibition of ex parte communication between any party and a member of the committee or the hearing officer. Final rules incorporating these procedures shall be adopted by the committee on or before October 1, 1988. 1987

26-23-3. Violation of public health laws or orders unlawful.

It shall be unlawful for any person, association, or corporation, and the officers thereof:

(1) to willfully violate, disobey, or disregard the provisions of the public health laws or the terms of any lawful notice, order, standard, rule, or regulation issued thereunder; or

(2) to fail to remove or abate from private property under the person's control at his own expense, within 48 hours, or such other reasonable time as the health authorities shall determine, after being ordered to do so by the health authorities, any nuisance, source of filth, cause of sickness, dead animal, health hazard, or sanitation violation within the jurisdiction and control of the department, whether the person, association, or corporation shall be the owner, tenant, or occupant of such property; provided, however, when any such condition is due to an act of God, it shall be removed at public expense; or

(3) to pay, give, present, or otherwise convey to any officer or employee of the department any gift, remuneration or other consideration, directly or indirectly, which such officer or employee is forbidden to receive by the provisions of this chapter.

(4) to fail to make or file reports required by law or rule of the department relating to the existence of disease or other facts and statistics relating to the public health. 1981

26-23-4. Unlawful acts by department officers and employees.

It shall be unlawful for any officer or employee of the department:

(1) To accept any gift, remuneration, or other consideration, directly or indirectly, for an incorrect or improper performance of the duties imposed upon him by or in behalf of the department or by the provisions of this chapter.

(2) To perform any work, labor, or services other than the duties assigned to him on behalf of the department during the hours such officer or employee is regularly employed by the department, or to perform his duties as an officer or employee of the department under any condition or arrangement that involves a violation of this or any other law of the state. 1981

26-23-5. Unlawful acts concerning certificates, records and reports - Unlawful transportation or acceptance of dead human body.

It shall be unlawful for any person, association, or corporation and the officers thereof:

(1) to willfully and knowingly make any false statement in a certificate, record, or report required to be filed with the department, or in an application for a certified copy of a vital record, or to willfully and knowingly supply false information intending that such information be used in the preparation of any such report, record, or certificate or amendment thereof;

(2) to make, counterfeit, alter, amend, or mutilate any certificate, record, or report required to be filed under this code or a certified copy of such certificate, record, or report without lawful authority and with the intent to deceive;

(3) to willfully and knowingly obtain, possess, use, sell, furnish, or attempt to obtain, possess, use, sell, or furnish to another, for any purpose of dec-

Utah Code Ann. § 26-23-2(3)

411 Exempt Assets

Allow the following exemptions for medical assistance cases other than Indigent Medical cases. See Section 807 for exemptions specific to Indigent Medical cases. If an asset is not treated in that section, use the F or C policy.

1. One Home and Lot - All Cases

Exclude one home, including a mobile home, and lot owned or being purchased and occupied by the client.

a. F and C Cases - The lot on which the home stands shall not exceed the average size of residential lots in the community where it is. Count the equity value of property exceeding an average size lot.

b. A, B and D Cases - Exempt the home and all contiguous property.

Exempt a life estate in a home if the owner of the life estate continues to live in the home.

2. One Home and Lot of a Person in a Nursing Home - All Cases

When a person who owns a home, or life estate in a home, becomes a resident of a nursing home, the home or life estate becomes countable unless:

a. The person's stay in the nursing home will be short term. A stay is short term if a doctor says that the client is likely to return home within 6 months of admission. Anyone in a nursing home more than 6 months after admission is long term.

or b. The person states that he intends to return home. It does not matter whether the person actually returns home within 6 months. There is no time limit to this exemption. The statement of intent must be in writing from the client or his representative.

or c. The person has a spouse, dependent child, or relative* who lives in the home.

3. Water Rights - All Cases

Exclude water rights attached to a house and lot.

Relative: son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, half-sister, half-brother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, or stepsister

18 years of age or older and permanently and totally disabled.

(3) Federal financial participation is available in assistance payments made for the entire month in accordance with the State plan if the individual was eligible for a portion of the month, provided that the individual was eligible on the date that the payment was made; except that where it has been determined that the State agency had previously denied assistance to which the individual was entitled, Federal financial participation will be provided in any corrective payment regardless of whether the individual is eligible on the date that the corrective payment is made.

(4) Federal financial participation is available in assistance payments which are continued in accordance with the State plan, for a temporary period during which the effects of an eligibility condition are being overcome, e.g., blindness in AB, disability in APTD, physical or mental incapacity, continued absence of a parent, or unemployment of a principal earner in AFDC.

(5) Where changed circumstances or a hearing decision makes the individual ineligible for any assistance, or eligible for a smaller amount of assistance than was actually paid, Federal financial participation is available in excess payments to such individuals, for not more than one month following the month in which the circumstances changed or the hearing decision was rendered. Federal financial participation is available where assistance is required to be continued unadjusted because a hearing has been requested.

(Sec. 1102, Social Security Act, as amended, 49 Stat. 647, as amended; 42 U.S.C. 1302 and Part XXIII of Pub. L. 97-35, 95 Stat. 843)

[36 FR 3866, Feb. 27, 1971, as amended at 38 FR 8744, Apr. 6, 1973; 39 FR 26912, July 24, 1974; 40 FR 32958, Aug. 5, 1975; 47 FR 5674, Feb. 5, 1982; 47 FR 47828, Oct. 28, 1982; 51 FR 9204, Mar. 18, 1986]

§ 233.20 Need and amount of assistance.

(a) *Requirements for State Plans.* A State Plan for OAA, AFDC, AB, APTD or AABD must, as specified below:

(1) *General.* (i) Provide that the determination of need and amount of assistance for all applicants and recipients will be made on an objective and equitable basis and all types of income will be taken into consideration in the same way except where otherwise specifically authorized by Federal statute and

(ii) Provide that individuals receiving SSI benefits under title XVI, for the period for which such benefits are received, shall not be included in the AFDC assistance unit for purposes of determining need and the amount of the assistance payment. Under this requirement, "individuals receiving SSI benefits under title XVI" includes individuals receiving mandatory or optional State supplementary payments under section 1616(a) of the Act or under section 212 of Pub. L. 93-66.

(2) *Standards of assistance.* (i) Specify a statewide standard, expressed in money amounts, to be used in determining (*a*) the need of applicants and recipients and (*b*) the amount of the assistance payment.

(ii) In the AFDC plan, provide that by July 1, 1969, the State's standard of assistance for the AFDC program will have been adjusted to reflect fully changes in living costs since such standards were established, and any maximums that the State imposes on the amount of aid paid to families will have been proportionately adjusted. In such adjustment a consolidation of the standard (i.e., combining of items) may not result in a reduction in the content of the standard. In the event the State is not able to meet need in full under the adjusted standard, the State may make ratable reductions in accordance with paragraph (a)(3)(viii) of this section. Nevertheless, if a State maintains a system of dollar maximums these maximums must be proportionately adjusted in relation to the updated standards.

(iii) Provide that the standard will be uniformly applied throughout the State except as provided under § 239.54.

(iv) Include the method used in determining need and the amount of the assistance payment. For AFDC, the method must provide for rounding down to the next lower whole dollar

when the result of determining the standard of need or the payment amount is not a whole dollar. Proration under § 206.10(a)(6)(i)(D) to determine the amount of payment for the month of application must occur before rounding to determine the payment amount for that month.

(v) If the State agency includes special need items in its standard, (A) describe those that will be recognized and the circumstances under which they will be included, and (B) provide that they will be considered for all applicants and recipients requiring them; except that under AFDC, work expenses and child care (or care of incapacitated adults living in the same home and receiving AFDC) resulting from employment or participation in either a CWEP or an employment search program cannot be special needs.

(vi) If the State chooses to establish the need of the individual on a basis that recognizes, as essential to his well-being, the presence in the home of other needy individuals, (*a*) specify the persons whose needs will be included in the individual's need, and (*b*) provide that the decision as to whether any individual will be recognized as essential to the recipient's well-being shall rest with the recipient.

(vii) [Reserved]

(viii) Provide that the money amount of any need item included in the standard will not be prorated or otherwise reduced solely because of the presence in the household of a non-legally responsible individual; and the agency will not assume any contribution from such individual for the support of the assistance unit except as provided in paragraphs (a)(3)(xiv) and (a)(5) of this section and § 233.51 of this part.

(3) *Income and resources.* (i) (A) *OAA, AB, APTD, AABD,* Specify the amount and types of real and personal property, including liquid assets, that may be reserved, i.e., retained to meet the current and future needs while assistance is received on a continuing basis. In addition to the home, personal effects, automobile and income producing property allowed by the agency, the amount of real and personal property, including liquid assets, that can be reserved for each individual recipient shall not be in excess of two thousand dollars. Policies may allow reasonable proportions of income from businesses or farms to be used to increase capital assets, so that income may be increased; and (B) in AFDC—The amount of real and personal property that can be reserved for each assistance unit shall not be in excess of one thousand dollars equity value (or such lesser amount as the State specifies in its State plan) excluding only:

(*1*) The home which is the usual residence of the assistance unit;

(*2*) One automobile, up to $1,500 of equity value or such lower limit as the State may specify in the State plan; (any excess equity value must be applied towards the general resource limit specified in the State plan);

(*3*) One burial plot (as defined in the State plan) for each member of the assistance unit;

(*4*) Bona fide funeral agreements (as defined and within limits specified in the State plan) up to a total of $1,500 of equity value or such lower limit as the State may specify in the State plan for each member of the assistance unit;

(*5*) Real property for a period of six months (or at the option of the State, nine months) which the family is making a good faith effort (as defined in the State plan) to sell subject to following provisions. The family must sign an agreement to dispose of the property and to repay the amount of aid received during such period that would not have been paid had the property been sold at the beginning of such period, but not to exceed the amount of the net proceeds of the sale. If the property has not been sold within the specified time period, or if eligibility stops for any other reason, the entire amount of aid paid during such period will be treated as an overpayment; and

(*6*) At State option, basic maintenance items essential to day-to-day living such as clothes, furniture and other similarly essential items of limited value.

(ii) Provide that in determining need and the amount of the assistance payment, after all policies governing the

CALLY NEEDY INCOME STANDARDS

11 Medically needy income standls: General requirements.

letermine eligibility of medically individuals, a Medicaid agency use an income standard under ibpart that is—
lased on family size;
Jniform for all individuals in a d group;
'or FFP purposes, not in excess ⅓ percent of the highest money nt that ordinarily would be in the State AFDC program to ividual or a family of compara- e (see § 435.1007); and
teasonable (see § 435.812).

47987, Sept. 30, 1981]

2 Medically needy income standls: Reasonableness.

'he agency must use a medically income standard that is reason-

The following medically needy e standards are presumed to be able:
'he agency provides one medicaldy income standard for all covnedically needy groups. Except vided in paragraphs (c) and (d) s section, the standard must at qual the highest income or paytandard used to determine eligiin the cash assistance programs optional State supplement, if gency provides Medicaid under 30) related to the covered medieedy groups.
'he agency provides a different ılly needy income standard for overed medically needy group. ; as provided in paragraphs (c) l) of this section, the standard ch covered group must at least he income or payment standard o determine eligibility in the ssistance program (or an optione supplement, if the agency pro- Medicaid under § 435.230) relatthat covered medically needy

The agency may use a lower ılly needy income standard than andards specified in paragraph this section if—
'he income standard used under aph (b) of this section exceeds the maximum dollar amount on income allowed for purposes of FFP under § 435.1007; and

(2) The lower income standard at least equals the maximum amount allowed for purposes of FFP.

(d) In the case of an agency that provides Medicaid for the aged, blind, or disabled individuals only if they meet more restrictive requirements than used under SSI, the following provisions apply:

(1) The agency may use an income standard for those individuals that is lower than the standard specified in paragraph (b) of this section.

(2) The lower standard must at least equal the medically needy income standard for those aged, blind, or disabled individuals under the State's plan on January 1, 1972.

(e) If the agency uses a medically needy income standard not specified in paragraphs (b) through (d) of this section—

(1) That standard is not presumed to be reasonable; and

(2) HCFA must approve the standard.

[46 FR 47987, Sept. 30, 1981]

§ 435.813 [Reserved]

§ 435.814 Medically needy income standards: State plan requirements.

(a) The State plan must specify the income standard for each covered medically needy group.

(b) If the agency uses an income standard that is not presumed to be reasonable under § 435.812, the State plan must describe that standard.

[46 FR 47987, Sept. 30, 1981]

FINANCIAL RESPONSIBILITY OF RELATIVES

§ 435.821 Financial responsibility of relatives: Individuals under age 21 and caretaker relatives.

(a) The agency must meet the requirements of this section in determining eligibility—

(1) Under § 435.308 of medically needy individuals under age 21; and

(2) Under § 435.310 of medically needy caretaker relatives.

supplement recipients under § 435.230; or

(iii) The amount of the highest medically needy income standards for one person established under § 435.814.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the highest of the following need standards for a family of the same size:

(A) The standard used to determine eligibility under the State's approved AFDC plan.

(B) The standards used to determine eligibility under the State's Medicaid plan, as provided for in § 435.814.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(d) In determining the amount of the individual's income to be used to reduce the agency's payment to the institution, the agency may, for single individuals, deduct an amount (in addition to the personal needs allowance) for maintenance of the individual's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that the individual is likely to return to his home within that period.

[45 FR 24886, Apr. 11, 1980, as amended at 46 FR 47988, Sept. 30, 1981; 48 FR 5735, Feb. 8, 1983]

MEDICALLY NEEDY RESOURCE STA

§ 435.840 Medically needy resource ards: General requirements.

To determine eligibility of me needy individuals, a Medicaid must use a resource standard this subpart that is—

(a) Based on family size;

(b) Uniform for all individua group; and

(c) Reasonable. (See § 435.841

[46 FR 47988, Sept. 30, 1981; 46 FI Nov. 11, 1981]

§ 435.841 Medically needy resourc ards: Reasonableness.

(a) The agency must use a m needy resource standard that sonable, according to the provi this section.

(b) The following medically resource standards are presume reasonable:

(1) The agency provides one r ly needy resource standard for ered medically needy groups. as provided in paragraph (c) section, the standard must equal the highest resource s used to determine eligibility cash assistance programs rel the covered medically needy gr

(2) The agency provides a d medically needy resource stan each covered medically needy Except as provided in paragra this section, the standard for e ered group must at least eq highest resource standard use termine eligibility in the cas ance program related to that medically needy group.

(c) In the case of an agency t vides Medicaid for the aged, disabled individuals only if th more restrictive requiremen used under SSI, the followin sions apply:

(1) The agency may use a standard for those individual lower than the standard spe paragraph (b) of this section.

(2) The lower standard mus equal the medically needy standard for those aged, blin abled individuals under the plan on January 1, 1972.

) If the agency uses a medically
ly resource standard not specified
aragraphs (b) and (c) of this sec-
–
That standard is not presumed to
asonable; and
HCFA must approve the stand-

R 47988, Sept. 30, 1981; 46 FR 54743,
1, 1981]

343 Medically needy resource stand-
ds: State plan requirements.

The State plan must specify the
rce standard for each covered
ally needy group.
If the agency uses a resource
ard that is not presumed to be
nable under § 435.841, the State
nust describe that standard.

47989, Sept. 30, 1981]

MINING ELIGIBILITY ON THE BASIS OF RESOURCES

45 Medically needy resource eligi-
ity.

letermine eligibility on the basis
ources for medically needy indi-
s, the agency must—
Consider only the individual's re-
s and those that are considered
ble to him under the financial
sibility requirements for rela-
in § 435.821, § 435.822, or
23;
Consider only resources available
the period for which income is
ted under § 435.831(a);
For individuals under age 21 and
er relatives, deduct the value of
es that would be deducted in
ining eligibility under the
AFDC plan;
For aged, blind, or disabled indi-
in States covering all SSI re-
s, deduct the value of resources
uld be deducted in determining
ity under SSI;
) For aged, blind, or disabled in-
ls in States using requirements
estrictive than SSI, deduct the
f resources in an amount no
estrictive than those deducted
he Medicaid plan on January 1,
d no more liberal than those
d in determining eligibility
SI.

(2) However, the amounts specified in paragraph (e)(1) of this section must be the same as those that would be deducted in determining, under § 435.121, the eligibility of the categorically needy; and

(f) Apply the resource standards established under § 435.843.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24886, Apr. 11, 1980; 46 FR 47989, Sept. 30, 1981]

TREATMENT OF INCOME AND RESOURCES

§ 435.850 Treatment of income and resources: General requirements.

To determine eligibility of medically needy individuals, a Medicaid agency must use a methodology for the treatment of income and resources that is—

(a) Uniform for all individuals in a covered group; and

(b) Reasonable (see § 435.851).

[46 FR 47989, Sept. 30, 1981]

§ 435.851 Treatment of income and resources: Reasonableness.

(a) The agency must use a methodology for the treatment of income and resources, to determine eligibility of the medically needy, that is reasonable.

(b) The methodology used to determine eligibility of individuals in the cash assistance program related to the covered medically needy group is presumed to be reasonable.

(c) If the agency provides Medicaid for the aged, blind, or disabled individuals who meet more restrictive requirements than used under SSI, the methodology for the treatment of income and resources of those aged, blind, or disabled individuals under the State's plan on January 1, 1972, is presumed to be reasonable.

(d) If the agency uses a methodology not described in paragraphs (b) and (c) of this section—

(1) The methodology is not presumed to be reasonable; and

(2) HCFA must approve that methodology.

[46 FR 47989, Sept. 30, 1981]

PROOF OF SERVICE

I hereby certify that I have mailed four true and correct copies of the above BRIEF OF PETITIONER to the Attorneys for Respondent: DAVID L. WILKINSON, Attorney General of Utah, at State Capitol Building, Salt Lake City, Utah 84114, and RUTH L. RENLUND, Assistant Attorney General, 236 State Capitol Building, Salt Lake City, Utah 84114, via First-class U.S. Mail, postage prepaid, this 9 day of June, 1988.

Michael E. Bulson

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Attorney for Petitioner